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Office of Administrative Law Judges
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Issue Date: 30 January 2007

In the Matter of:

J.O.,
On behalf of S.O.,
Claimant

Case No.: 2004-BLA-00147

v.

WHITAKER COAL CORPORATION,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Edmond Collett, Esq.
Edmond Collett, P.S.C.
Hyden, Kentucky
For the Claimant

Lois A. Kitts, Esq.
Baird & Baird
Pikeville, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING REQUEST FOR MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C.

§ 902(b); 20 CFR § 718.201 (2006). In this case, the Claimant alleges that her husband, a Miner, was totally disabled by pneumoconiosis.

I conducted a hearing on this claim on April 4, 2006, in Hazard, Kentucky. All parties were afforded full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2006). The Director, OWCP, was not represented at the hearing. The Claimant was the only witness. Transcript ("Tr.") at 19. Director's Exhibits ("DX") 1-135, Claimant's Exhibits ("CX") 1-3 and Employer's Exhibits ("EX") 1-4 were admitted into evidence without objection (Tr. at 8, 16). The record was held open for 90 days after the hearing to allow the parties to submit closing arguments. The Claimant and Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Miner filed his initial claim for benefits on November 15, 1996 (DX 1). The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on July 2, 1997 (DX 30). That claim was transferred to the Office of Administrative Law Judges and heard by Administrative Law Judge ("ALJ") Daniel Roketenetz.

On January 5, 1999, ALJ Roketenetz denied the claim (DX 35). In his denial, the Administrative Law Judge reviewed nine interpretations of five x-rays. He noted four positive interpretations and five negative interpretations. He found both the quantity of negative readings and the qualifications of the interpreting physicians dispositive and found that pneumoconiosis was not established through x-ray evidence. He then evaluated medical narratives provided by Drs. Myers, Broudy, Wicker, and Joyce. He discounted the opinions of Drs. Myers and Joyce, as they based their opinions on a positive x-ray when he had found the preponderance of x-ray evidence to be negative. No additional argument was provided by Drs. Myers or Joyce to support a diagnosis of pneumoconiosis beyond the x-ray interpretations. He assigned great weight to the reports of Drs. Broudy and Wicker who found no evidence of pneumoconiosis. He held that these physicians based their opinions on objective testing including normal pulmonary function studies, normal arterial blood gases, physical examinations and negative chest x-rays. Judge Roketenetz held that the preponderance of medical opinion evidence failed to establish the existence of pneumoconiosis.

In his analysis of total disability, Judge Roketenetz reviewed three nonqualifying pulmonary function tests (DX 7-9, 29) and two nonqualifying arterial blood gas tests (DX 8, 13). In review of medical opinion evidence, he noted that Drs. Myers, Broudy, and Wicker did not diagnose total disability, and that Dr. Joyce did not render an opinion on this issue. He found, therefore, that no medical opinion of record diagnosed total disability under the Act, and that the Miner was not entitled to benefits.

The Miner appealed the Decision to the Benefits Review Board (the "Board" or "BRB") on January 11, 1999 (DX 36). The Board affirmed Judge Roketenetz' denial and his analysis on August 31, 2000 (DX 46).

The Miner filed a second claim for benefits on May 15, 2001 (DX 53). In addition, on June 4, 2001, counsel for the Miner filed a Request for Modification and Motion to Voluntarily Withdraw Claim (DX 47). The District Director, OWCP, mistakenly entered a Proposed Decision and Order Withdrawal of Claim on June 6, 2001, stating that it would be in the Miner's best interest to withdraw the initial claim (DX 48, DX 50). However, the BRB later held that a claim may not be withdrawn after it has already been adjudicated and denied. *Clevenger v. Mary Helen Coal Co.*, 22 B.L.R. 1-193 (2002) (en banc); *Lester v. Peabody Coal Co.*, 22 B.L.R. 1-183 (2002) (en banc). In this case, the Miner's claim was denied by the Board on August 31, 2000, and the decision became effective on the date it was issued, pursuant to 20 CFR § 725.502(a)(2). As the Claimant did not file a timely appeal, the claim could not be withdrawn.

The Miner passed away on November 30, 2002 (DX 58). The District Director, OWCP, entered a Proposed Decision and Order Denial of Benefits on May 16, 2003 (DX 92). Claimant's counsel responded by requesting a formal hearing on the matter (DX 93). The Employer responded, arguing that the second claim of the Miner was not a subsequent claim, but rather was a request for modification under the regulations (DX 94). The District Director agreed with the Employer and vacated the withdrawal (DX 119). As the second claim of the Miner was filed less than one year from the Benefit Review Board's Decision, the District Director reviewed the claim again, this time, as a request for modification under the old regulations. The District Director issued a Proposed Decision and Order Denying Request for Modification on April 27, 2004. Claimant's counsel requested a formal hearing on May 3, 2004 (DX 99).

At the hearing, both parties present stipulated that the Miner's May 15, 2001, claim is properly treated as a request for modification of the earlier denial under the old regulations (Tr. 5-6).

APPLICABLE STANDARDS

This case pertains to a request for modification of an adverse decision of a claim filed on November 15, 1996. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2006). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920, *et seq.* (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. *See* 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2006). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding modification) do not; for a list of the revised sections which do **not** apply to pending cases, see 20 CFR § 725.2(c) (2006). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting

from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2 and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930 et seq. (2003). In this case, the Claimant filed his claim before the effective date of the new regulations. Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2006 edition.

Pursuant to 20 CFR § 725.310 (2000), in order to establish that the Miner was entitled to benefits, the Claimant must demonstrate that there has been a change in conditions or a mistake in determination of fact such that he met the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that the Miner suffered from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis was totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2006). Where modification is sought based on an alleged change in conditions, new evidence must be submitted and the Administrative Law Judge must conduct an independent assessment of the newly submitted evidence, in conjunction with the evidence previously submitted, to determine whether the weight of the evidence is sufficient to establish the element or elements which defeated entitlement in the prior decision. *Napier v. Director, OWCP*, 17 B.L.R. 1-111, 1-113 (1993); *Kovac v. BCNR Mining Corp.*, 14 B.L.R. 1-156, 1-158 (1990), *modified on recon.*, 16 B.L.R. 1-71 (1992). Where modification is sought based upon a mistake of fact, new evidence is not a prerequisite, and the adjudicator may resolve the issue based upon "wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 256 (1971); *Kovac v. BCNR Mining Shipyards, Inc.*, 16 B.L.R. 1-71, 1-73 (1992), *modifying* 14 B.L.R. 1-156 (1990).

ISSUES

The issues contested by the Employer, or by the Employer and the Director, are:

1. Whether the Miner had pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he was totally disabled.

4. Whether his disability was due to pneumoconiosis.

5. Whether the evidence establishes a change in conditions or a mistake in a determination of fact in the prior denial pursuant to 20 CFR § 725.310 (2000).

(DX 132; Tr. 13-14). At the hearing, the Employer withdrew the issues of timeliness, whether the Miner was a miner, post-1969 employment, length of employment, dependency, survivor, responsible operator, duplicate claim, and insurance (Tr. 13-14). The parties stipulated to 30 years of coal mine employment (Tr. 18). The Employer also reserved its right to challenge the statute and regulations.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

At the hearing, the Claimant was the only witness. She testified that she and the Miner married in 1963 (Tr. 19; DX 105). They were still married at the time of his death, and she has not remarried; they had no other dependents (Tr. 25-26). The Claimant testified that all of the Miner's coal mine employment was underground, and that he regularly returned home from work covered in coal dust (Tr. 21). She testified that her husband's breathing difficulties kept getting worse and that he had to use a Nebulizer machine and inhalers for relief (Tr. 22). The Miner could not walk 40 feet without stopping to rest (Tr. 23). He died unexpectedly while driving home from a store (Tr. 24-25).

The parties stipulated to 30 years of coal mine employment (Tr. 18). The stipulation is supported by the record (*see* DX 1-5, 101-104), and I find that the Claimant has established at least 30 years of coal mine employment. The Miner's last coal mine employment was in April 1995, in the Commonwealth of Kentucky (Tr. 20; DX 3). Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*). The Miner stopped working because the company closed down; after that, he received Social Security disability benefits (Tr. 20). The Miner also received state black lung benefits (DX 57).

Medical Evidence

The Benefits Review Board affirmed Judge Roketenetz' prior findings. Moreover, for the reasons stated below, considering the old and new evidence together, I have found a change in conditions, but no mistake of fact in the prior denial of the Miner's claim. It is unnecessary, therefore, to recite again the medical evidence before Judge Roketenetz, which is incorporated by reference.

Autopsy

An autopsy was performed at the time of the Miner's death, after the Board affirmed Judge Roketenetz' decision. An autopsy may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2006). Section 718.106(a) provides that an autopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. Greater weight may be accorded to a physician who performs the autopsy over one who reviews the autopsy slides. *Peabody Coal Co. v. Shonk*, 906 F.2d 264, 269 (7th Cir. 1990); *U.S. Steel Corp. v. Oravetz*, 686 F.2d 197, 200 (3d Cir. 1982); *Gruller v. Bethenergy Mines, Inc*., 16 B.L.R. 1-3 (1991); *Similia v. Bethlehem Mines Corp*., 7 B.L.R.1-535, 1-539 (1984); *Cantrell v. U.S. Steel Corp*., 6 B.L.R. 1-1003, 1-1006 (1984). An autopsy report may be given greater weight than x-ray reports. *Griffith v. Director, OWCP*, 49 F.3d 184, 187 (6th Cir. 1995), citing *Peabody Coal Co. v. Shonk*, 906 F.2d 264, 269 (7th Cir.1990).

The record contains the autopsy protocol from Hazard ARH Hospital (DX 71). The autopsy was performed on December 2, 2002 by Dr. Antônio Abalos. After macroscopic and microscopic evaluation, Dr. Abalos diagnosed simple coal miners' pneumoconiosis, cardio-megaly with left and right ventricular hypertrophy, coronary atherosclerosis with focal calcification, mild to moderate, and focal myocardial scarring. The diagnosis of pneumoconiosis was based on microscopic evaluation of the lungs.

Dr. Joseph Tomashefski, a Board-certified Pathologist, performed a records review at the request of the Employer (DX 110). Dr. Tomashefski reviewed the Miner's treatment records, and the autopsy slides, and opined that the Miner suffered from severe atherosclerotic and hypertensive cardiac disease with congestive heart failure, massive cardiomegaly, biventricular myocardial hypertrophy, and cardiac arrhythmias. He opined that autopsy slides showed coal macules, micro nodules, and focal emphysema, demonstrating that the Miner had mild simple coal workers' pneumoconiosis. He opined that the Miner's pneumoconiosis did not cause any significant respiratory or pulmonary impairment. He said that the pulmonary function test showed mild abnormalities explained by obesity, cardiac disease, and mild reactive airways changes. Normal arterial oxygen levels also indicated that coal workers' pneumoconiosis did not cause hypoxemia.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with the current request for modification. As noted above, Judge Roketenetz found the weight of the x-ray evidence before him to be negative. The Board affirmed that finding, and I do not find any mistake of fact in light of the new x-ray evidence. Indeed, all but one of the readings of the four more recent x-rays read in connection with the request for modification are negative. As the more recent evidence is entitled to greater weight, the more recent x-ray evidence simply confirms Judge Roketenetz' and the Board's finding that the x-ray evidence is negative. Therefore, I have not included the x-ray evidence before Judge Roketenetz in the table below. In any event, the autopsy evidence is sufficient to establish the existence of pneumoconiosis, despite the negative x-ray evidence.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B, or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, and 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2006). Any such readings are, therefore, included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by

judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH). Qualifications of physicians are abbreviated as follows: A=NIOSH certified A reader; B=NIOSH certified B reader; BCR=Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	**Read as Positive for Pneumoconiosis**	**Read as Negative for Pneumoconiosis**	**Silent as to the Presence of Pneumoconiosis**
05/30/95			Pampati (DX 68) Cardiomegaly
12/13/00			Pampati (DX 68) Cardiomegaly
03/14/01			Bofill (DX 68) Cardiomegaly. Granulomatous disease suggested.
04/25/01[1]	Baker, B 1/2 t/q (DX 107, DX 62)	Wheeler, B/BCR Negative (DX 65)	
09/26/01		Hussain[2] Negative (DX 61) Hayes, B/BCR Negative (DX 67)	Sargent, B/BCR Quality only, Good (DX 61)
12/14/01		Broudy, B Negative (DX 64)	
08/15/02		Hayes, B/BCR Negative (DX 109)	

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). A CT scan was taken of the Claimant's chest on March 28, 1991, due to a question of an enlarged heart. The Radiologist's impression stated there was no evidence of cardiomegaly or any mass

[1] I find this x-ray to be negative, based on the more extensive qualifications of Dr. Wheeler.

[2] According to the NIOSH website, Dr. Hussain became an A reader on March 1, 2002, after he read this x-ray. Thus, he had no special qualifications at the time he read it.

in the lung (DX 68). In another CT scan taken on September 2, 1997, the lungs were clear (DX 68). Another CT scan was taken on June 5, 2002, due to hemoptysis. The Radiologist's impression was multiple nodes in the aorticopulmonary window and carinal area, as well as hilar nodes (DX 71, DX 68). Yet another CT scan was taken on August 15, 2002. The original report is not in the file. However, Dr. Hayes, a Board-certified Radiologist who read the scan for the Employer, said there was no evidence of pneumoconiosis on the CT scan (DX 109).

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. Tests most often relied upon to establish disability in black lung claims measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with this request for modification. As noted above, all three pulmonary function studies reviewed by Judge Roketenetz resulted in nonqualifying values. I have found no mistake of fact in light of the new pulmonary function test results. For this reason, and because the newer tests are entitled to greater weight, I have not included the tests before Judge Roketenetz on the chart. Nonetheless, I have considered them together with the new evidence, and none show values qualifying for disability. On the chart, "pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2006).

Ex. No. Date Physician	**Age Height**[3]	**FEV_1 Pre-/ Post**	**FVC Pre-/ Post**	**FEV_1/ FVC Pre-/ Post**	**MVV Pre-/ Post**	**Qualify?**	**Physician Impression**
DX 62, DX 107 04/25/01 Baker	56 72"	2.60	3.78	69%	108	No	Mild obstructive defect. Tracings included, Coop./comp. not noted.
DX 69 05/22/01 Baker	56 72"	2.95	3.89	76%	---	No	Tracings included, Coop./comp. not noted

[3] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). I find the Miner's height to be 72.5".

Ex. No. Date Physician	Age Height[3]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 107 DX 69 07/24/01 Baker	56 72”	3.45	4.34	79%	---	No	Tracings included, Coop./comp. not noted
DX 61 09/26/01 Hussain	56 73”	3.04 3.16	4.30 4.62	70.7% 68.4%	96 --	No	Mild obstruction
DX 64 12/14/01 Broudy	57 183 cm (72”)	2.89 3.32	3.85 4.31	75% 77%	102 128	No No	Variable effort, normal readings after bronchodilator.
DX 69 05/13/02 Baker	57 72”	2.94	4.07	72%	---	No	Tracings included, Coop./comp. not noted
CX 1 06/04/02 Koura	57 73”	2.42 2.65	3.22 3.40	75.2% 77.9%		No No	Normal spirometry [printed]; Moderate, fixed obstructive disease [hand written]

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this request for modification. A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2006). As noted above, the results of both arterial blood gas studies reviewed by Judge Roketenetz were nonqualifying. I have found no mistake of fact in light of the new arterial blood gas studies. Therefore, for this reason, and because the newer tests are entitled to greater weight, I have not included the tests before Judge Roketenetz on the chart. Nonetheless, I have considered them together with the new evidence, and none shows values qualifying for disability.

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
DX 62, DX 107	04/25/01	Baker	37	81	No	Normal
DX 61	09/26/01	Hussain	40.4 34.3	73.0 93.0	No	Mild hypoxemia
DX 64	12/14/01	Broudy	35.8	82.2	No	Normal

Other Medical Opinions

Medical opinions are relevant to the issues of whether the miner had pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2006). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2006). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contra-indicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2006). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2006). The record contains the following medical opinions submitted in connection with the request for modification.

The record contains 177 pages of hospitalization reports from Hazard ARH (DX 68) and an additional 21 pages submitted separately (DX 66), from 1991 to 2002. There are occasional diagnoses of chronic obstructive pulmonary disease (COPD) and coal workers' pneumoconiosis (CWP) contained in the records. None of the hospitalizations related to his pulmonary diagnoses, except for a bronchoscopy conducted in June 2002 due to hemoptysis. Bronchoscopy showed evidence of bilateral bleeds without evidence of endobronchial tumors or pathology report consistent with malignancy. The Miner was discharged home after his symptoms improved with medical treatment. Treatment notes from that period reflect an acute exacerbation of COPD as well hemoptysis. Most of the Miner's hospital visits pertained to diagnosis and treatment of his serious and progressive heart disease.

The Employer submitted six pages of treatment notes from Dr. Vidya Yalamanchi from January to September 2001 (DX 63). According to the American Board of Medical Specialties,[4] Dr. Yalamanchi is Board-certified in Internal Medicine and Cardiovascular Disease. All treatment was heart related, and the Miner's chest was found to be clear with no rales or wheezing. The record also contains 12 additional pages of treatment records from Dr. Yalamanchi at the Appalachian Heart Center from September 2001 to July 2002 (DX 108). Treatment continued to center on follow-up of the Miner's heart disease. The Miner's chest was consistently clear with no clubbing, rales, or wheezing. COPD was noted as one of the Miner's diagnoses in those records.

Dr. Glen Baker examined the Miner on April 25, 2001, at the request of the Miner's counsel (DX 107, 62). Dr. Baker is Board-certified in Internal Medicine and Pulmonary Disease, and a B reader (CX 2). Based on symptomatology (sputum, cough, wheezing, dyspnea), employment history (32 years coal mine employment), individual and family histories (short of breath), smoking history (two packs per day for 10 years, quitting in 1969), physical examination (diminished breath sounds bilaterally), chest x-ray (1/2), pulmonary function study (mild obstructive ventilatory defect), and an arterial blood gas study (normal), Dr. Baker diagnosed CWP, COPD, and bronchitis. He based his diagnosis of pneumoconiosis on a positive x-ray interpretation and a history of coal dust exposure. He based his diagnosis of COPD on pulmonary function testing, and he diagnosed bronchitis, based on history. He opined that the Miner suffered from a Class II impairment and a second impairment, based on Chapter 5, *Guides to the Evaluation of Permanent Impairment, Fifth Edition*, which states that persons who develop pneumoconiosis should limit further exposure to the offending agent. He went on to state, "[t]his would imply the patient is 100% occupationally disabled for work in the coal mining industry or similar dusty occupations."

The record also contains medical treatment notes from Dr. Baker from May 2001 to November 2002 (DX 69, DX 107). Diagnoses included CWP, COPD, and ischemic heart disease (IHD) with angina pectoris. Dr. Baker's notes also reflect left bundle branch block and a smoking history of two packs per day for 10 years. Most of the handwritten entries, however, are illegible.

Dr. Imtiaz Hussain examined the Miner on September 26, 2001, on behalf of the Department of Labor (DX 60). According to the American Board of Medical Specialties, Dr. Hussain is Board-certified in Internal Medicine and Pulmonary Disease. Based on symptomatology (sputum, wheezing, dyspnea, cough), employment history (30 years coal mine employment), individual and family histories (high blood pressure, heart disease, cancer, allergies, stroke), smoking history (non smoker), physical examination (normal), chest x-ray (congestive heart failure), pulmonary function study (mild airway obstruction), arterial blood gas study (mild hypoxemia), and an EKG (left bundle branch block), Dr. Hussain diagnosed congestive heart failure due to hypertension and coronary artery disease. He opined that the Miner did not suffer from occupational lung disease, and that he suffered no pulmonary or respiratory impairment. He based his opinion on physical examination, chest x-ray and laboratory testing results.

[4] Information about physician board certifications appears on the website of the American Board of Medical Specialties, found at http://www.abms.org.

Dr. Bruce C. Broudy, a Board-certified Internist, Pulmonologist, and B reader, examined the Miner on December 14, 2001, on behalf of the Employer (DX 64). Based on symptomatology (short of breath, chest pains, cough, sputum), employment history (32 years underground coal mining), individual and family histories (hypertension, coronary artery disease, arthritis, prior appendectomy), smoking history (1-2 packs per day for 10 years), physical examination (lungs clear to auscultation and percussion), chest x-ray (negative), pulmonary function study (normal), and an arterial blood gas study (normal), Dr. Broudy diagnosed obesity, hypertension, history of coronary artery disease, history of left bundle branch block, and a history of chronic bronchitis. He opined that the Miner did not suffer from coal workers' pneumoconiosis. He based his diagnosis on a normal physical examination, negative x-ray evidence, and normal pulmonary function and arterial blood gas studies, which he opined strongly suggested that the Miner's dyspnea was nonpulmonary in origin. He further opined that the Miner retained the respiratory and pulmonary capacity to return to his previous coal mine employment. He based that assessment on normal pulmonary function and arterial blood gas readings.

Dr. Firas A. Koura submitted a response to a questionnaire from the Miner's counsel dated February 10, 2003, along with eight pages of treatment notes on the Miner from March 2001 to November 2002, and the results of a pulmonary function study administered on June 4, 2002 (DX 72, *see also* DX 70). Dr. Koura re-submitted the treatment notes and pulmonary function study under cover of a letter dated January 29, 2004 (CX 1). According to the website maintained by the American Board of Medical Specialties, Dr. Koura is Board-certified in Internal Medicine. Dr. Koura stated that he examined the Miner on multiple occasions and on a regular basis. He opined that the Miner suffered from coal workers' pneumoconiosis based on x-ray findings and the autopsy of the Miner. He did not list the x-rays relied upon in making his determination. He said there was no pulmonary disease other than that caused by coal dust. The treatment notes were mostly illegible. Consistent in the notes however, are notations for COPD, coronary artery disease, and coal workers' pneumoconiosis. The record of the pulmonary function test administered on June 2, 2004, has contradictory entries regarding the results ("normal" and "moderate fixed obstructive disease").[5]

Dr. David Rosenberg, a Board-certified Internist, Pulmonologist, and Occupational Medicine Specialist (EX 3), performed a review of the Miner's medical records, and prepared a report dated March 8, 2006, at the request of the Employer (EX 1). Dr. Rosenberg reviewed treatment notes, medical opinions, laboratory testing, and the autopsy report. He opined that objective testing performed prior to death showed that the Miner did not suffer from pneumoconiosis. Only after autopsy slides were reviewed, was the existence of mild simple pneumoconiosis discovered. He opined that from a functional perspective, the Miner showed no significant restriction or obstruction and therefore no impairment. He specifically ruled out any clinically significant COPD or legal pneumoconiosis based on normal FEV_1/FVC ratios.

Dr. Matthew Vuskovich, a Board-certified Occupational Medicine Specialist (EX 4), also reviewed the Miner's medical records in March 2006 at the request of the Employer (EX 2). After review of the record evidence, Dr. Vuskovich opined that while x-ray and CT scans did not show pneumoconiosis, microscopic examination of the lungs did demonstrate mild

[5] Dr. Rosenberg suggested a third alternative, stating that this study showed a mild restriction, but a month before, restriction was not noted (EX 1). Dr. Vuskovich said these results demonstrated moderate to mild impairment of an unspecified nature (EX 2).

pneumoconiosis. He opined that pulmonary function studies and arterial blood gases demonstrated that the Miner had no pulmonary impairment.

The record contains the Commonwealth of Kentucky Certificate of Death for the Miner (DX 58). The Certificate of Death listed the immediate cause of death as hypertensive heart disease and coronary artery disease. No underlying causes of death were listed. Under "Other significant conditions contributed to death but not resulting in the underlying cause," coal workers' pneumoconiosis, COPD, and recurring hemoptysis were listed. The Certificate was completed by the Deputy Coroner of Leslie County, Kentucky.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical,' pneumoconiosis and statutory, or 'legal,' pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> > (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2006).

Twenty CFR § 718.202(a) (2006) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners who died on or before March 1, 1978); or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. None of the presumptions apply in this claim. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider chest x-rays, autopsy evidence and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Under § 718.202(a)(2), the presence of pneumoconiosis may be established by autopsy evidence. The autopsy protocol from Hazard ARH demonstrates microscopic evidence of pneumoconiosis. Every pathologist and other physician who reviewed the autopsy slides and/or the autopsy report agreed that the microscopic evidence demonstrated the existence of mild, simple coal workers' pneumoconiosis. I find that autopsy evidence establishes the existence of pneumoconiosis under § 718.202(a)(2), and I find that the Claimant has established a change in conditions since the previous denial of the Miner's claim under § 725.310.

I agree with Judge Roketenetz and the Board that the weight of the x-ray evidence before Judge Roketenetz was negative. Moreover, I find that all four more recent x-rays read in connection with the black lung claim are also negative. None of the x-rays taken in connection with treatment refer to pneumoconiosis, although one was considered suggestive of granulomatous disease. Thus, the x-ray evidence establishes neither a mistake of fact, nor a change in conditions. Similarly, the CT scan evidence does not refer to pneumoconiosis.

I must next consider the medical opinions. The Claimant can establish that the Miner suffered from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a

physical examination, symptoms, and the patient's work, and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, *above*. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a Judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994).

The record contains hospitalization records from Hazard ARH, treatment records from Appalachian Heart Center, and heart-related treatment notes from Dr. Yalamanchi. These records document heart related conditions, and when they included a diagnosis of either COPD or pneumoconiosis, there was no supporting documentation. I find that these records are not supportive of the existence of pneumoconiosis.

After his initial examination of the Miner, Dr. Baker diagnosed pneumoconiosis, COPD, and bronchitis. He based his diagnosis of pneumoconiosis on a positive x-ray interpretation and a history of coal dust exposure. However, I have found the x-ray on which he relied to be negative. Nonetheless, his diagnosis was later confirmed on autopsy. Dr. Baker also diagnosed COPD due to coal dust exposure, based on pulmonary function testing. Thus, Dr. Baker found that both clinical and legal pneumoconiosis were present. I find that Dr. Baker based his conclusions on sufficient documentation and reasoning, and give his opinion probative weight.

Dr. Hussain diagnosed congestive heart failure due to coronary artery disease. Dr. Hussain based his opinion on objective testing and he documented which evidence supported his opinion. Dr. Hussain did not have access to the Miner's autopsy records when making his diagnosis. I find Dr. Hussain's opinion to be well reasoned, but based on older and incomplete medical information. I give his opinion little weight.

Dr. Broudy, diagnosed obesity, hypertension, a history of coronary artery disease, a history of left bundle branch block, and a history of chronic bronchitis. He based his opinion on objective testing, and he documented, which readings supported his opinion. Dr. Broudy also did not have access to the Miner's autopsy records. Noting Dr. Broudy's superior credentials, I find his opinion to be well reasoned, but based on older and incomplete medical information. I also give his opinion little weight.

Dr. Koura was one of the Miner's treating physicians. He opined that the Miner suffered from coal worker's pneumoconiosis based on x-ray evidence and upon autopsy findings. He did not list the x-rays relied upon in making his determination, and I have found the x-ray evidence before me to be negative. Nonetheless, as Dr. Koura's diagnosis was supported by the autopsy evidence, I give his opinion some weight.

Dr. Rosenberg opined that treatment notes, medical opinions, and all objective testing performed prior to death did not show the existence of pneumoconiosis. He opined, however, that microscopic evaluation of the autopsy slides demonstrated the existence of mild simple pneumoconiosis. Dr. Rosenberg based his opinion on objective evidence. He evaluated the conflicting evidence, and explained that only upon microscopic examination of the autopsy slides was pneumoconiosis discovered. Noting Dr. Rosenberg's superior credentials, I give this opinion great weight supporting the existence of pneumoconiosis.

Dr. Vuskovich opined that while x-rays did not show the presence of pneumoconiosis, microscopic examination of the lungs at autopsy did demonstrate the existence of simple pneumoconiosis. Dr. Vuskovich based his opinion on objective evidence and documented which evidence supported his opinion. Given Dr. Vuskovich's credentials as a Board-certified Occupational Medicine Specialist, I give his well-reasoned opinion great weight.

In the final analysis, I find that the all physicians who reviewed the autopsy protocol found the existence of pneumoconiosis demonstrated by microscopic autopsy evidence. Their opinions are collectively well reasoned and based on objective evidence. In addition, one physician diagnosed legal pneumoconiosis. I find that in addition to the autopsy, the Claimant has also established that the Miner had pneumoconiosis on the basis of medical opinion evidence.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2006). Claimant was employed as a miner for at least 30 years, and therefore is entitled to the presumption. With no evidence presented to rebut the presumption, I conclude that Claimant's pneumoconiosis was caused by his coal mine employment.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2006), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2006). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. 20 CFR § 718.204(b) and (d) (2006). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a

finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2006); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Miner suffered from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2006); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

In the instant case, none of the previously or newly submitted pulmonary function or arterial blood gas studies produced qualifying values indicative of total disability. Therefore, total disability cannot be established under 20 CFR § 718.204(b)(i) or (ii) (2006). Furthermore, of the physicians who examined the Claimant or reviewed his medical records, Drs. Myers, Broudy, Wicker, Rosenberg, Vuskovich, Tomashefski, and Hussain found that the Claimant was not disabled. Drs. Joyce and Koura did not make a determination whether the Claimant was totally disabled. Dr. Baker found that the Claimant was disabled based on the premise that a miner who develops pneumoconiosis should limit further exposure to coal mine dust. This, in and of itself, does not constitute a finding of disability under the regulations or case law. *See Zimmerman v. Director, OWCP*, 871 F.2d 564, 567 (6th Cir. 1989). The Claimant testified that her husband's breathing kept getting worse and that he could not walk over 40 feet without stopping to rest. While this testimony supports total disability, the physicians of record opined that with essentially normal pulmonary function and arterial blood gas testing, the miner's dyspnea was nonpulmonary in origin.

When the lay testimony is considered in conjunction with the physician opinions and the results of the objective testing, I find that the Claimant has failed to establish that the Miner was totally disabled by a pulmonary or respiratory impairment.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has established a change in conditions, in that the Miner had pneumoconiosis arising out of his coal mine employment, but has failed to establish that he suffered from a totally disabling pulmonary or respiratory impairment. Accordingly, the Miner was not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The request for modification filed by the Miner on May 15, 2001, and pursued on his behalf by the Claimant, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC, 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC, 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).